STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056267	A. Building B. Wing	03/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Camino Healthcare	13922 Cerise Avenue Hawthorne, CA 90250

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to: 1. Ensure licensed nursing staff informed Residents 13 and 91 of the medications being administered prior to administration. 2. Ensure Residents 13 and 91 were given an opportunity to participate during medication administration. These deficient practices violated Residents 13 and 91's rights.Findings: During a review of Resident 13's Face Sheet, the face sheet indicated Resident 13 was initially admitted to the facility on [DATE] and readmitted to the facility on [DATE] with diagnoses that included type 2 diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), heart failure, and age-related osteoporosis (weak and brittle bones due to lack of calcium and Vitamin D). During a review of Resident 13's History and Physical (H&P) dated 11/1/2025, the H&P indicated Resident 13 does not have the capacity to understand and make decisions. During a review of Resident 13's Minimum Data Set (MDS, a resident assessment tool), dated 12/12/2025, The MDS indicated Resident 13 usually had the ability to make self understood and usually had the ability to understand others. The MDS indicated Resident 13 was dependent on staff for toileting, bathing, lower body dressing, and personal hygiene. During a review of Resident 91's Face Sheet, the face sheet indicated Resident 91 was initially admitted to the facility on [DATE] with diagnoses that included hemiplegia and hemiparesis (total paralysis of the arm, leg, and trunk on the same side of the body, and weakness), facial weakness, and type 2 diabetes mellitus. During a review of Resident 91's H&P dated 1/27/2026, the H&P indicated Resident 91 does not have the capacity to understand and make decisions. During a review of Resident 91's MDS dated [DATE], the MDS indicated Resident 91 had the ability to make self understood and the ability to understand others. The MDS indicated Resident 91 required maximal assistance (helper does more than half the effort) for toileting, bathing, and lower body dressing. During an observation on 3/12/2026 at 9:17 AM in Resident 13's room, Licensed Vocational Nurse (LVN) 3 was observed giving Resident 13 six medicine cups without explaining what medications were in the cups. Resident 13 then swallowed the pills. During an observation on 3/12/2026 at 9:33 AM in Resident 91's room, LVN 3 was observed giving Resident 91 nine medicine cups without explaining what medications were in the cups. Resident 91 then swallowed the pills and liquid medications. During an interview on 3/12/2026 at 11:40 AM with LVN 3, LVN 3 stated she was taught to inform the residents the names of medications being administered prior to administering. During an interview on 3/12/2026 at 11:57 AM with the Director of Nursing (DON), the DON stated the nurses are trained to explain the medications to residents prior to administration. The DON stated it is important to inform residents of the medication because they have the right to refuse. During a review of the Policy and Procedure (P&P) titled Administration of Drugs, revised 5/2020, the P&P failed to identify the federally required content element that licensed nurses must explain to residents the type of medication being administered and the procedure.

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to: 1. Ensure one of three residents (Resident 72) had a care plan for the residents' dialysis (a treatment to cleanse the blood of wastes and extra fluids artificially through a machine when the kidney(s) have failed) emergency kit (e-kit) not being kept in Resident 72's room. This deficient practice had the potential to delay immediate access to emergency supplies needed in case of unexpected complications such as bleeding from the dialysis shunt (access site for dialysis) or rapid evacuation from the facility.Findings:During a review of Resident 72's admission Record, the admission record indicated Resident 72 was admitted to the facility on [DATE], with diagnoses including end stage renal disease (ESRD - irreversible kidney failure), dependence on renal dialysis, and type 2 diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing) with diabetic chronic kidney disease. During a review of Resident 72's History and Physical (H&P), dated 4/26/2025, the H&P indicated Resident 72's capacity for medical decision making was waxing and waning (increasing and decreasing). During a review of Resident 72's Minimum Data Set (MDS, a resident assessment tool), dated 1/28/2026, the MDS indicated Resident 72 usually had the ability to make self understood and usually had the ability to understand others. The MDS indicated Resident 72 was independent with eating, lower body dressing, putting on/taking off footwear, and personal hygiene. The MDS indicated Resident 72 received dialysis as a special treatment. During a review of Resident 72's Order Summary Report, dated 4/23/2025, the order summary report indicated Resident 72 was on dialysis treatment every Tuesday, Thursday, and Saturday. The order summary report indicated to assess the dialysis site every shift for tenderness, redness, and bleeding. During an observation on 3/11/2026 at 10:20 AM in Resident 72's room, there was no dialysis e-kit in the room. During a concurrent observation and interview on 3/11/2026 at 11:00 AM in Resident 72's room with Licensed Vocational Nurse (LVN) 1, LVN 1 stated he did not know why the dialysis e-kit was not in Resident 72's room, but it should be available for emergencies. LVN 1 did not know where the e-kit was located. During an observation and interview on 3/11/2026 at 11:12 AM in Resident 72's room with the Director of Staff Development (DSD), the DSD stated Resident 72's dialysis e-kit should be kept at the bedside but due to the resident throwing out the contents because he did not want the bag there, the e-kit was kept at nursing station 2 so it would remain intact and ready in case of emergency. During a review of the facility's Policy and Procedures (P&P) titled Comprehensive Person-Centered Care Planning revised 4/2025, the P&P indicated The resident has the right to refuse or discontinue treatment. In the event that a resident refuses certain services posing a risk to resident's health and safety, the comprehensive care plan will identify care or service declined, the associated risks, IDT's effort to educate the resident and resident representative and any alternate means to address risk. During a review of the facility's P&P titled Resident Assessment and Associated Processes revised 12/2023, the P&P indicated The assessment process will include direct observation and communication with residents, as well as communication with licensed and non-licensed direct care staff members on all shifts. The P&P indicated Assessment information will be used to develop, review, and revise the resident's comprehensive care plan.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to: 1. Revise and update person-centered care plans to reflect current physician orders, oxygen flow rate and gastrostomy tube feeding rate for two of 20 sampled residents (Resident 30 and 53). This failure had the potential to result in implementation of incorrect care interventions and placed residents at risk for respiratory compromise and nutritional imbalance. Findings:a. During a review of Resident 30's Face Sheet, the Face Sheet indicated Resident 30 was admitted to the facility on [DATE]. Resident 30's diagnoses included respiratory failure with hypoxia (a serious condition that makes it difficult to breathe on your own), congestive heart failure (CHF-a heart disorder which causes the heart to not pump the blood efficiently), asthma with acute exacerbation (a chronic disease making it difficult to breathe with sudden worsening of asthma symptoms), pulmonary hypertension (a condition that affects the blood vessels in the lungs), and acute pulmonary edema (a condition in which fluid builds up in the lungs, making it difficult to breathe). During a review of Resident 30's Minimum Data Set ([MDS], a standardized assessment and care planning tool), dated 1/14/2026, the MDS assessed Resident 30 as having moderate cognitive (difficulty with thinking) impairment in daily decision making. The MDS indicated Resident 30 required staff assistance with activities of daily living (ADLs) including toileting, showering, dressing and transferring and required maximal assistance for positioning, oral hygiene and eating, with staff performing more than half of the effort. During a review of Resident 30's Order Summary Report (physician order), dated 1/16/2026, the physician order indicated oxygen was to be administered at 2 L/min continuously via nasal canula. During a concurrent interview and record review on 3/11/2026 at 1:45 p.m. with Licensed Vocational Nurse (LVN) 2, Resident 30's care plans were reviewed. The care plan for altered respiratory status did not reflect the physician order of continuous oxygen flow rate. LVN 2 stated the care plan showed oxygen at 4 L/min via nasal cannula while the physician ordered 2 L/min and confirmed the care plan should have been revised when the order was implemented. b. During a review of Resident 53's Face Sheet, the Face Sheet indicated Resident 53 was admitted to the facility on [DATE] and readmitted on [DATE]. Resident 53's diagnoses included Parkinson's disease (a progressive disease of the nervous system marked by tremor, muscular rigidity, and slow, imprecise movements), Alzheimer's Disease (a disease characterized by a progressive decline in mental abilities), and gastrostomy (a surgical opening fitted with a device to allow feedings to be administered directly to the stomach common for people with swallowing problems). During a review of Resident 53's History and Physical (H&P), dated 1/30/2026, the H&P indicated, Resident 53 did not have the capacity to understand and make decisions. During a review of Resident 53's MDS, dated [DATE], the MDS assessed Resident 53 as having moderate cognitive (difficulty with thinking) impairment in daily decision making. The MDS indicated Resident 53 required total staff assistance with ADLs including oral hygiene, toileting, showering, dressing and transferring and positioning. During a review of Resident 53's physician order, dated 2/25/2026, the physician order indicated continuous g-tube feeding at 60 mL/hour for 20 hours. During a concurrent interview and record review on 3/12/2026 at 11:58 a.m. with Minimum Data Set (MDS) Coordinator, Resident 53's care plans were reviewed, the care plan for altered nutrition/hydration did not reflect the physician order of continuous g-tube feeding at 60 mL/hour. The MDS Coordinator stated the care plan documented g-tube feeding at 70 mL/hour for 20 hours and confirmed the care plan should have been revised to reflect the current physician order. During an interview on 3/13/2026 at 11:30 a.m., with the Director of Nursing (DON), the DON stated nursing staff are responsible for ensuring care plans reflected current physician orders and confirmed staff were expected to revise care plans when changes occurred, including new physician orders. During a review of the policy and procedure (P&P) titled, Comprehensive Person-Centered Care Planning, dated 4/2025, indicated, resident's (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	comprehensive plan of care will be reviewed and/or revised by the IDT after each assessment, including bother the comprehensive and quarterly review assessments.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to: 1. Ensure one of five sampled residents (Resident 7) the physician was notified when there was sediment (the solid matter that settles to the bottom of a liquid, such as urine or blood) in the indwelling catheter (a medical device inserted into the bladder to drain urine continuously) tubing. This deficient practice not notifying the physician of the sediment in the indwelling catheter tubing had the potential to cause a urinary tract infection ([UTI]- an infection in any part of the urinary system). During a review of Resident 7's admission Record (front page of the chart that contains a summary of basic information about the resident), indicated Resident 7 was admitted to the facility on [DATE] and readmitted [DATE]. Resident 7 diagnoses included chronic obstructive pulmonary disease([COPD]- a chronic lung disease causing difficulty in breathing), pressure ulcers (localized damage to the skin and/or underlying tissue usually over a bony prominence), and paraplegia (loss of movement and/or sensation, to some degree, of the legs). During a review of Patient 7's History and Physical (H&P), dated 5/6/2025, the H&P indicated, Resident 7 had fluctuated capacity to understand and make decisions. During a review of Resident 7's Minimum Data Sheet ([MDS]- a resident assessment tool), dated 1/4/20206, the MDS indicated Resident 7's cognition (ability to learn, reason, remember, understand, and make decisions) was intact. The MDS indicated Resident 7 was dependent (helper does all the effort and resident does none of the effort to complete the activity) on staff for toileting hygiene, showering, and dressing. During an observation on 3/10/2026 at 10:00 a.m., in Resident 7's room, Resident 7 had an indwelling catheter. The indwelling catheter had sediment in the tubing. During a review of Resident 7's care plan, High risk for resident with indwelling catheter, dated 8/20/2024, the care plan indicated to monitor, record, and report to the physician for signs and symptoms of UTI. During a concurrent observation and interview on 3/11/2026 at 8:11 a.m., with Director of Staff Development (DSD), in Resident 7's room, Resident 7 had an indwelling catheter. The indwelling catheter had sediment in the tubing. The DSD stated there was a large amount of sediment in Resident 7's indwelling catheter tubing. The DSD stated during nursing rounds the indwelling catheter should have been assessed. The DSD stated the physician should have been notified immediately so the nursing staff would know what to do. The DSD stated sediment in the indwelling catheter was an indication of possible UTI or infection. During a concurrent observation and interview on 3/11/2026 at 10:07 a.m., with Licensed Vocational Nurse (LVN) 4, in Resident 7's room, Resident 7 had an indwelling catheter. The indwelling catheter had sediment in the tubing. LVN 4 stated the sediment should have been reported to the physician. LVN 4 stated nursing was responsible for monitoring signs and symptoms of possible infection. LVN 4 stated not notifying the physician of the sediment could lead to an aggressive infection and make Resident 7 uncomfortable. During a review of facility policy and procedure (P&P) titled, Significant Change of Condition, Response, dated 12/2023, the P&P indicated the facility will ensure each resident quality of care and services to attain and maintain. The P&P indicated recognized conditions or care needs of the resident had changed the Licensed Nurse or Nurse Supervisor should be aware not limited to any signs or symptoms of infection.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to: 1. Ensure Resident 30 received oxygen at the physician ordered flow rate of 2 liters/minute (L/min).2. Ensure Resident 34's oxygen tank was secured and properly stored. These deficient practices had the potential to result in adverse outcomes, including respiratory compromise, oxygen toxicity, carbon dioxide retention, or injury related to an unsecured oxygen tank. Findings: a. During a review of Resident 30's Face Sheet, the Face Sheet indicated Resident 30 was admitted to the facility on [DATE]. Resident 30's diagnoses included respiratory failure with hypoxia (a serious condition that makes it difficult to breathe on your own), congestive heart failure (CHF-a heart disorder which causes the heart to not pump the blood efficiently), asthma with acute exacerbation (a chronic disease making it difficult to breathe with sudden worsening of asthma symptoms), pulmonary hypertension (a condition that affects the blood vessels in the lungs), and acute pulmonary edema (a condition in which fluid builds up in the lungs, making it difficult to breathe) During a review of Resident 30's Minimum Data Set ([MDS], a standardized assessment and care planning tool), dated 1/14/2026, the MDS assessed Resident 30 as having moderate cognitive (difficulty with thinking) impairment in daily decision making. The MDS indicated Resident 30 required staff assistance with activities of daily living (ADLs) including toileting, showering, dressing and transferring and required maximal assistance for positioning, oral hygiene and eating, with staff performing more than half of the effort. During an observation on 3/11/2026 at 1:45 p.m. in Resident 30's room with Licensed Vocational Nurse (LVN) 2 present, the surveyor observed Resident 30 lying in bed receiving oxygen via nasal cannula at a flow rate of 3.5 L/min. During a concurrent interview and record review on 3/11/2026 at 1:45 p.m. with LVN 2, Resident 30's physician orders were reviewed, the physician order indicated oxygen was to be administered at 2 L/min continuously. LVN 2 stated, the observed setting did not match the physician's order and confirmed staff were expected to follow physician orders when administering oxygen. LVN 2 stated incorrect oxygen settings could harm the resident, including the risk of carbon dioxide retention, and acknowledged the resident received oxygen above the ordered rate. During an interview on 3/13/2026 at 11:30 a.m., with the Director of Nursing (DON), the DON stated nursing staff were responsible for administering treatments, including oxygen, in accordance with physician orders and verifying the correct treatment prior to administration. The DON stated failure to follow physician orders could result in resident harm. During a review of the policy and procedure (P&P) titled, Medication Administration - Administration of Drugs, dated 5/2020, indicated, medications shall be administered as prescribed by the attending physician. Medications must be administered in accordance with the written orders of the attending physician. b. During a review of Patient 34's admission Record (front page of the chart that contains a summary of basic information about the resident), indicated Patient 34 was admitted to the facility on [DATE] and readmitted [DATE]. Resident 34's diagnoses included chronic obstructive pulmonary disease([COPD]- a chronic lung disease causing difficulty in breathing), dependence on supplemental (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	oxygen (a person requiring an external, higher concentration of oxygen delivered via tanks), and dementia (a progressive state of decline in mental abilities). During a review of Patient 34's History and Physical (H&P), dated 8/21/2025 the H&P indicated, Resident 34 had fluctuated capacity to understand and make decisions. During a review of Resident 34's Minimum Data Sheet ([MDS]- a resident assessment tool), dated 11/29/25, the MDS indicated Resident 34's cognition (ability to learn, reason, remember, understand, and make decisions) was severely impaired. The MDS indicated Resident 34 was dependent (helper does all the effort and resident does none of the effort to complete the activity) on staff for personal hygiene, showering, and dressing. During an observation on 3/10/2026 at 10:30 a.m., in Resident 34's room, an oxygen tank was in an upright position without a holder to support the oxygen tank. During a concurrent observation and interview on 3/10/2026 at 3:40 p.m., with Director of Staff Development (DSD), in Resident 34's room, there was an oxygen tank in an upright position without a holder to support the oxygen tank. The DSD stated the oxygen tank needed to be secured. The DSD stated the when the oxygen tank was no longer being used; it should be placed in the oxygen storage room. The DSD stated if the oxygen tank was to fall it could burst and explode. The DSD stated if the oxygen tank was to burst it could cause harm. During a concurrent observation and interview on 3/10/2026, with Licensed Vocational Nurse (LVN) 4, in Resident 34's room, there was an oxygen tank in an upright position without a holder to support the oxygen tank. LVN 4 stated the oxygen tank was not secured. LVN 4 stated if the oxygen tank was to fall it could combust (able to catch fire and burnt easily) and could harm Resident 34. During a review of the policy and procedures (P&P) titled, Oxygen Handling and Storage, dated 2/2022, the P&P indicated it was the policy of the facility to provide use and handling of oxygen tanks in the facility. The P&P indicated storage of oxygen tanks must be accompanied in a safe manner. Oxygen tanks must be secured to a wall within a chain or heavy cable. Safety cups will be installed on all tanks not in use.

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F 0711 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the resident's doctor reviews the resident's care, writes, signs and dates progress notes and orders, at each required visit. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to: 1. Ensure one of five sampled residents (Resident 7) had followed recommended physician orders for Resident 7's foot care. This deficient practice of not following the physician's recommendation orders caused a delay in foot care treatment for Resident 7. Findings:During a review of Resident 7's admission Record (front page of the chart that contains a summary of basic information about the resident), indicated Resident 7 was admitted to the facility on [DATE] and readmitted [DATE]. Resident 7 diagnoses included chronic obstructive pulmonary disease([COPD]- a chronic lung disease causing difficulty in breathing), pressure ulcers (localized damage to the skin and/or underlying tissue usually over a bony prominence), and paraplegia (loss of movement and/or sensation, to some degree, of the legs). During a review of Patient 7's History and Physical (H&P), dated 5/6/2025, the H&P indicated, Resident 7 had fluctuated capacity to understand and make decisions. During a review of Resident 7's Minimum Data Sheet ([MDS]- a resident assessment tool), dated 1/4/20206, the MDS indicated Resident 7's cognition (ability to learn, reason, remember, understand, and make decisions) was intact. The MDS indicated Resident 7 was dependent (helper does all the effort and resident does none of the effort to complete the activity) on staff for toileting hygiene, showering, and dressing. During a record review of Resident 7's Convalescent Podiatry Care Evaluation & Treatment, dated 3/6/2026, the physician had recommended Clotrimazole (treat skin infections) 1 percentage ([%]- a way of expressing a number as a fraction) cream to be applied to affect area daily and Vitamin A and Vitamin D ([A&D]- topical skin protectant) ointment to be applied daily. During a concurrent interview and record review on 3/11/2026 at 8:11 a.m., with Director of Staff Development (DSD), Resident 7's Convalescent Podiatry Care Evaluation & Treatment, dated 3/6/2026 was reviewed. The physician had recommended Clotrimazole 1% cream to be applied to affect area daily and A&D ointment to be applied daily. The DSD stated the physician recommendations were not followed. The DSD stated when Resident 7 was seen by the physician the treatment should have been started. The DSD stated not following the recommendations had caused a delay in care and treatment for Resident 7. The DSD stated this could make Resident 7's condition worse. During a concurrent interview and record review on 3/11/2026 on 8:27 a.m., with Social Services Director (SSD), Resident 7's Convalescent Podiatry Care Evaluation & Treatment, dated 3/6/2026 was reviewed. The physician had recommended Clotrimazole 1% cream to be applied to affect area daily and A&D ointment to be applied daily. The SSD stated that after Resident 7 was seen by the physician the recommendations of treatment were not started. The SSD stated the recommendations should have been brought to the attention of the nurses to start the medical treatment. The SSD stated it was important for Resident 7 to start her treatment to prevent things from getting worse. During a review of the facility's policy and procedure (P&P) titled, Dental, Optometry, and Audiology Evaluations, dated 1/2016, the P&P indicated Social Services will maintain a system to monitor the Podiatry evaluations. The P&P indicated Social Services staff member will request that nursing obtain a physician's order for evaluations prior to scheduling of appointments. During a review of the facility's P&P titled, Resident Assessment, dated 2/2024, the P&P indicated drugs shall be administered only upon the written order of a person duly licensed and authorized to prescribe the drugs. The P&P indicated orders for drugs and treatments shall be received and must be recorded immediately in the residents' chart by the person receiving the order.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation and interview, the facility failed to: 1. Ensure one of five opened medication containers was dated with the open date. This failure had the potential to affect residents who receive medications requiring dating to ensure potency.Findings: During an observation on 3/12/2026 at 08:15 AM, Licensed Vocational Nurse (LVN) 2 administered medication from an opened bottle of Ferrous Sulfate (a medication used to restore iron levels in the blood), that was not labeled with the date it was opened. During an interview on 3/12/2026 at 1121 AM with LVN 2, LVN 2 stated, That bottle should have been labeled with the date when it was first opened to know when to remove it from the cart after 30 days. Without knowing how long ago it was opened, there is no way to know if it would possibly be effective. Residents could still have low iron levels if the medicine does not work anymore. A review of the facility's policy and procedure (P&P) titled, Medication Storage in the Facility, dated May 2022, the P&P indicated, When the original seal of a manufacturer's container or vial is initially broken, the container or vial will be dated.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review the facility failed to: 1.Dispose of an unlabeled and undated bag of spinach in the kitchen refrigerator.2. Dispose of cardboard boxes under the kitchen hand washing sink. 3. Cover the bulk container of oatmeal. 4. Ensure two bottles of Gatorade were not stored in the meat freezer. 5. Label the bottle titled, Spice with a list of ingredients and a use by date.These failures had the potential to expose residents to infectious microorganisms (germs), pests, and allergic reactions.Findings:During a concurrent observation and interview on 3/10/2026 at 8:30 a.m., in the kitchen, a Ziplock bag of spinach, with a milky white substance, was observed in the kitchen refrigerator, next to the tomatoes. Dietary Staff 1 (DS1) stated the spinach should be labeled with a date and was not able to identify the white milky substance. DS1 stated if the spinach were served to a resident, it could cause the resident to complain or become ill. During a concurrent observation and interview on 3/10/2026 at 8:42 a.m., with DS1, in the dry goods storage room, the oatmeal bin was uncovered. The DS1 stated the oatmeal should always be covered, if not, dirty stuff from outside could get into the bin, as well as bugs and dust. During a concurrent observation and interview on 3/10/2026 at 8:43 a.m., with the Director of Staff Development (DSD), in the dry goods storage room, the DSD stated the oatmeal bin should be covered, if not, bugs can get into the oatmeal. During a concurrent observation and interview on 3/10/2026 at 8:45 a.m., with the DSD, in the kitchen, the DSD stated the Gatorade should not be in the meat freezer. Food for the residents should be stored separately from staff's food. During a concurrent observation and interview with the Dietary Manager (DM) on 3/10/2026 at 9:03 a.m., the DM stated: The Ziplock bag of spinach should have a date indicating when it was placed in the refrigerator and discarded due to not having a date and the milky substance could make the residents sick.Empty cardboard boxes could harbor pests and bugs and should be taken outside and not stored in the kitchen.The open oatmeal bin should always have the lid closed, if not, bugs and dust can contaminate the oatmeal and affect the residents.The bottles of Gatorade should not be in the freezer with the residents' food.The container labeled, Spice should have a use by date and an ingredient list, or residents could have an allergic reaction to the unknown ingredients. During a review of the facility's policy and procedure titled, Labeling and Dating of Foods policy and procedure (P&P), dated 2023, the P&P indicated that the individual opening or preparing a food shall be responsible for date marking at the time of processing and/or storage. In addition, if the manufacturer dating shows a product is either kept longer or shorter time frame the facility will consider that date as the Use by. During a review of the facility's policy and procedure titled, Dry Goods Storage Guidelines, dated 2023, the guidelines indicated storage guidelines are based on the FoodKeeper App (U.S. Department of Health & Human Services). During a review of the State Operations Manual/Appendix PP (SOM), dated 7/23/2025, the SOM indicates that the facility should store, prepare, distribute and serve food in accordance with professional standards for food service safety. During an interview on 3/13/2026 at 11:49 p.m., with the DSD, the DSD stated the facility does not have policies for the disposal of cardboard boxes and outdoor trash bin disposal.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056267	A. Building B. Wing	03/13/2026

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F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Dispose of garbage and refuse properly. Based on observation, interview, and record review, the facility failed to: 1. Ensure two of three outside trash bins properly contained with covers that were completely closed. This failure had the potential to attract pests and vermin to the area which is adjacent to the laundry room.Findings: During a concurrent observation and interview on 3/10/2026 at 8:53 a.m., with the DSD, at the trash bin storage area, two large trash bins were overfilled and partially covered. The DSD stated the trash bins should be covered because rodents and other animals can get into the trash. During an interview on 3/13/2026 at 11:49 p.m., with the DSD, the DSD stated the facility does not have policies for the disposal of cardboard boxes and outdoor trash bin disposal. During a review of the State Operations Manual-Appendix PP (SOM), dated 7/23/2025, the SOM indicated the facility must properly contain refuse (trash) and dispose of it properly.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to: 1. Ensure a sign for Enhanced Barrier Precautions (infection control measure to stop germ spread), was displayed, for one of six residents, Resident 104, in Resident 104's room. This failure had the potential to expose staff and visitors to an infectious organism when touching or caring for Resident 104.Findings: During a review of Resident 104's admission Record, dated 3/4/2026, the admission Record indicated Resident 104 has cellulitis (a common, potentially serious bacterial skin infection) of the right lower limb, methicillin resistant staphylococcus aureus infection (a type of staph bacteria that causes infections resistant to many common antibiotics), and hemiplegia (partial paralysis) & hemiparesis (weakness or inability to move on one side of the body) affecting the left non-dominant side. During a review of Resident 104's History & Physical (H&P), dated 3/6/2026, the H&P indicated Resident 104 has the capacity for making medical decisions and was discharged from a hospital to the facility for care of a nonhealing right lower extremity wound, initially inflicted by a burn. During a review of Resident 104's Minimum Data Set (MDS), dated [DATE], the MDS indicated Resident 104 receives occupational and physical therapy and has a BIMS (brief interview for mental status) of 15, indicating Resident 104 is intact cognitively (mental processes involved in knowing, learning, and understanding). During a review of Resident 104's Care Plan Report, dated 3/5/2026, the Care Plan indicated: Resident 104 has an infection of the right lower extremity and staff are to maintain standard precautions when providing care. Resident 104 is on antibiotic therapy for a right leg wound infection with a goal to be free of any discomfort or adverse side effects of antibiotic therapy.Resident 104 is on enhanced barrier precautions for MDRO (a type of germ-usually bacteria-that has developed resistance to multiple, commonly used antibiotics) which requires visitors and staff to use gowns and gloves for personal careResident 104 requires supervision and assistance for toilet use, repositioning themself in bed, and with personal hygiene. During a review of Resident 53's admission Record, dated 1/28/2025, the admission Record indicated Resident 53 has Parkinson's and Alzheimer's Diseases. During a review of Resident 53's Minimum Data Set (MDS), dated [DATE], the MDS indicated Resident 53:Does not speak, is rarely/never understood, and rarely understands others.Is moderately impaired at making decisions.Uses a wheelchair. During a review of Resident 53's History & Physical (H&P), dated 1/30/2026, the H&P indicated that Resident 53 does not have capacity to understand and make decisions. During a review of Resident 53's Care Plan Report, dated 12/1/2025, the Care Plan Report indicated Resident 53 is on enhanced barrier precautions, will remain free of infections, and staff are to follow enhanced barrier precautions, utilize gowns and gloves for all personal care. During an observation on 3/10/2026 at 9:55 a.m., in room [ROOM NUMBER]A, there was an isolation cart at the right-side entry wall, but no isolation sign on the door or inside Resident 104's room. During an interview on 3/10/2026 at 10:00 a.m., with CNA1, CNA1 stated yes, there should be a sign. If there is no sign there, we would not know what type of isolation items to wear before going into the room. During an interview on 3/12/2026 at 2:18 p.m., with Infection Preventionist (IP), IP stated the enhanced barrier signs (EBP) signs are posted over the head of the bed so families can see it when residents have wound infections. The IP stated the isolation sign was found on the floor, near the head of Resident 104's bed and was placed on the wall at the head of the bed. The IP stated if the sign is not available for visitors to see, they will not know what to do to protect themselves from organisms and they can spread it to others. During a record review of the policy & procedure titled, IPCP (Interprofessional Collaborative Practice) Standard and Transmission-Based Precautions (extra infection control measures used in healthcare settings for patients known or suspected to be infected with highly transmissible pathogens) Policy & Procedure (P&P), dated 3/2024, indicated, EBP: used in conjunction with standard precautions (all blood, body fluids, non-intact skin, and mucous membranes should be treated as potentially infectious) and expand the use of PPE through the use of gown and (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	gloves during high-contact resident care activities that provide opportunities for indirect transfer of MDROs (bacteria or other microorganisms that have developed resistance to multiple classes of antimicrobial drugs, making them difficult to treat), to staff hands and clothing then indirect transferred to residents or from resident-to-resident (e.g., resident with wounds and indwelling medical devices are at especially high risk of both acquisition of and colonization with MDRPs). PPE (Personal Protective Equipment) specialized clothing or gear worn to minimize exposure to hazards that cause injuries, illnesses, or infections : The use of gowns and gloves for high-contact resident care activities is indicated, when Contact Precautions do not otherwise apply, for nursing home residents with wounds and/or indwelling medical devices regardless of known MDRO infection or colonization.